

82 10/18/12

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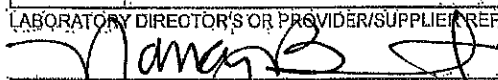
PRINTED: 10/02/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION USING A. BUILDING _____ and Surveys B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F-000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA-Certified Nurse Aide DON-Director of Nursing LPN-Licensed Practical Nurse MDS-Minimum Data Set RN-Registered Nurse MAR-Medication Administration Record TAR-Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers.	F 156	F156 The medical record for resident #19 was reviewed and corrected to reflect the appropriate resuscitation status and the resident's wishes on 10/10/12. All items now correlate together in showing the resident's resuscitation status. A new code status form will be completed each time a resident is admitted/readmitted to the facility. The IDT team will review each resident's resuscitation status in quarterly IDT meetings. Any changes needing to be made will be made immediately to ensure all documentation a resident's code status is complete, accurate, and correlates together. Any concerns found by the IDT team will be addressed immediately and reported in the quarterly QA meeting.	10/8/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 10/10/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Accepted w/changes per Nancy Banet NHA on 10/18/12
FORM CMS-2567 (02-99) Previous Versions Obsolete Even ID: V12221 Facility ID: WY0025 If continuation sheet Page 1 of 37

DOC=10/31/12 

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930	
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F 158	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 158		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the Wyoming Revised Statutes, the facility failed to ensure the advance directives filed in the medical record accurately reflected the resuscitation status for 1 of 10 sample residents	F 156			

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F 156	Continued From page 3 (#19). The findings were: Review of the medical record showed resident #19 had a signed document dated 1/13/12 to show s/he wanted to be resuscitated in the event of a respiratory or cardiac arrest. Review of the care plan last updated on 9/10/12 showed the resident's resuscitation status was "do not resuscitate." An interview with the DON on 9/20/12 at 11:55 AM revealed the document in the resident's chart did not reflect the resident's current wishes for resuscitation. He said the resident had changed his/her wishes from "resuscitate" to "do not resuscitate" and that the medical record document should be corrected. The DON said the care plan was accurate, however, interview on 9/19/12 at 7:30 PM with the MDS coordinator revealed she would refer to the medical record to determine what the resident's code status was, not the care plan. Review of the Wyoming Revised Statutes, Title 35, Chapter 22, 35-22-404 showed: "An individual with capacity may revoke all or part of an advance directive...at any time and in any manner that communicates an intention to revoke. Any oral revocation shall, as soon as possible after the revocation, be documented in a writing signed and dated by the individual or a witness to the revocation."	F 156		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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F-250	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure psychosocial needs were met for 1 of 9 sample residents (#7). The findings were: Review of the social services notes written on 7/30/12 and timed at 2:50 PM revealed resident #7 was "more depressed" and had little interest in doing things. Review of the July 2012, August 2012, and September 2012 MARs, revealed the resident had been taking the antidepressant Prozac for several years. According to her notes the social worker informed nursing staff of the resident's increased depression so they could inform the physician. Interview with the DON on 9/20/12 at 12:15 PM revealed the resident had just learned s/he had throat cancer. The following concerns were identified: a. Review of the entire nursing notes written after 7/30/12 revealed no evidence the physician was informed or that nursing addressed the resident's increased depression and lack of interest in activities of daily living. b. Review of the entire medical record showed no evidence the designated social worker followed up with assessing, re-assessing, or addressing the resident's increased depression and loss of interest in daily activities. Review of the social services notes revealed the next time the resident was charted on by social services was on 9/6/12 at 3:59 PM (38 days later) and these notes indicated the resident approached her to assist him/her in preparing a living will. According to the notes, the resident said s/he had throat cancer and s/he just wanted as little pain as possible, otherwise nothing heroic. These	F 250	F 250 A new psychosocial assessment and PHQ-9 was completed for resident #7 on 10/10/12. It was determined that the score had decreased and that the comparison between scores was situational based on the circumstances in his/her life when the previous assessment was completed. The resident reported on 10/10/12 that he/she was not feeling depressed or needing additional interventions at this time. Upon completion of a psychosocial assessment, PHQ-9, or visit with a resident that indicates increased depression or need for additional intervention, the Resident Advocate (RA) /Social Service Director (SSD) will contact the physician's office or other mental health professional. The RA/SSD will also place the resident on a "hot watch" which will allow for each shift to monitor the resident's condition until resolved. Any concerns will be corrected immediately and will be reported to the QA committee on a quarterly basis.	10/10/12	

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F 250	Continued From page 5 notes also indicated the resident wanted to be changed from a full resuscitation to a do not resuscitate status. o. Interview with the DON on 9/20/12 at 12:15 PM verified he was unable to find additional information in regard to treating this resident's increased depression. He said the resident was already on an antidepressant medication (Prozac) but perhaps it was not working based upon the resident's new terminal diagnosis. Interview with the social services designee on 9/20/12 at 9:05 AM revealed she was new as a social service designee and was still learning which issues should have follow-up.	F 250			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272			

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F 272	Continued From page 6 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure comprehensive assessments were performed in a variety of areas for 3 of 7 sample residents (#10, #17, #40). The findings were: 1. Review of the 4/20/12 quarterly and 7/18/12 significant change MDS assessments, section J, for resident #17 showed the interview and assessment for pain was not done. 2. Review of the 5/14/12 annual MDS assessment, section J, for resident #40 showed an interview and assessment for pain was not conducted. 3. Review of the 7/3/12 quarterly MDS assessment for resident #10 showed sections C and D were not completed for cognitive pattern	F-272	F 272 1. The quarterly MDS 4/20/12 and 7/18/12 significant change MDSs were reviewed for resident #17. It was found that section J was completed and the staff assessment for pain was done at the time of the assessment. The PDF file that was generated for printing was found to be defective and corrected. 2. The annual 5/14/12 MDS assessment for resident #40 was reviewed and found to be correct. It was found that section J was completed and the staff assessment for pain was done at the time of the assessment. The PDR file that was generated for printing was found to be defective and corrected. 3. A new comprehensive assessment will be completed for resident #10 by 10/31/12. This assessment will accurately reflect the resident's current level of function. Training will be completed with the RA/SS to ensure correct, accurate completion of sections C and D of the MDS. <i>Audit 10 percent to ensure completion of section C & D done MDS consult.</i>	10/31/12	

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F 272	Continued From page 7 and mood.	F 272			
F 278 SS=D	4. Interview with the MDS coordinator on 9/20/12 at 12 PM revealed she was not aware the assessments were not completed and did not know why those sections were blank. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F 278 1. A new comprehensive assessment will be completed for resident #10 by 10/31/12. This assessment will accurately reflect the resident's current level of function. 2. MDS dated 7/18/12 for resident #17 will be revised by 10/31/12 to reflect the accurate weight of the resident. Ten percent of all completed MDS assessments will be audited for accuracy by the MDS consultant once per month. Any concerns will be addressed immediately and reported to the QA committee.	10/31/12	

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F 278	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the MDS assessments accurately reflected the resident's status for 2 of 7 sample residents (#10, #17). The findings were: 1. Review of the 4/11/12 admission MDS assessment, section B, showed resident #10 could make him/herself understood and usually understood verbal content, comprehending most of a conversation. Review of sections C and F showed the interviews were not conducted because the resident rarely/never understood. Interview with the MDS coordinator on 9/20/12 at 12 PM verified sections C and D were inaccurate because the resident did understand verbal content and could make him/herself understood. 2. Review of the 7/18/12 significant change MDS assessment for resident #17 showed s/he triggered for nutritional status. However, review of the MDS section K (K0200) revealed the resident's weight was not recorded. This section was left blank.	F 278			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279			

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F 279	Continued From page 9 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a care plan to include measurable objectives to meet the resident's needs for 5 of 10 sample residents (#7, #10, #18, #37, #40). The findings were: 1. Review of the 4/11/12 admission MDS assessment, section V, for resident #10 showed s/he was to have care plans developed in the following care areas: visual function, pressure ulcers, and falls. In addition, review of the MAR showed the resident received medication for pain. The following concerns were identified: a. Review of the 4/11/12 care area assessment (CAA) for visual function showed the resident had difficulty watching the television or "reading material of interest." In addition, the resident had reading glasses. Review of the care plan last updated on 9/5/12 showed a care plan was not developed for visual function. b. Review of the 4/11/12 CAA for pressure ulcers showed the resident sat in a recliner "the	F 279	F 279 1. The care plans for resident #10 were reviewed. Care plans were found to be accurate and in place for the following areas: visual deficit, pressure ulcer risk, and fall risk. A care plan for pain management was developed for resident #10 by 10/31/12. 2. A care plan for nutrition was developed for resident #18 by 10/31/12. A care plan for oral/dental care was developed for resident #18 on 10/31/12. 3. Care plans for all of the following areas were developed for resident #37 by 10/31/12: vision impairment, activities of daily living, nutrition, oral/dental care, and pain. 4. A care plan for visual impairment was developed for resident #7 by 10/31/12. 5. Care plans for nutrition, hydration, and oral/dental care were developed for resident #40 by 10/31/12. One-third of completed comprehensive assessments each quarter will be audited and presented to QA committee for the next nine months and as needed thereafter. The QA committee will be making sure care plans are being completed for areas that are triggered on section V of the MDS. Any concerns will be addressed and corrected immediately.	10/31/12 <i>Nancy Rasmussen</i>

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F 279	Continued From page 10 majority" of his/her day. In addition, the resident had altered mobility. Observation on 9/18/12 from 9:15 AM through 11:45 AM showed the resident sat in his/her recliner the entire two and one-half hours. Review of the care plan last updated on 9/5/12 showed a care plan was not developed for pressure ulcers. c. Review of the 4/11/12 CAA for falls showed the resident had impaired balance during transitions and weakness. Review of the 9/13/12 nursing notes timed at 4:20 PM showed the resident fell. Review of the care plan last updated on 9/5/12 showed a care plan had not been developed for falls. d. Review of the August 2012 and September 2012 MARS showed the resident received the medication Tramadol 50 milligrams for general pain 16 times between 8/2/12 and 9/7/12. Review of the care plan showed a care plan was not developed for pain management. 2. Review of the 6/22/12 annual MDS, section V, for resident #18 showed s/he was to have care plans developed in the following areas; nutritional status and dental care. The following concerns were identified: a. Review of the 6/22/12 CAA for nutritional status showed the resident was on a no added salt diet with ground texture. In addition, s/he was on weekly weight monitoring because s/he was at risk for "poor nutrition." Review of the care plan last updated on 9/10/12 showed a care plan had not been developed for nutrition. b. Review of the 6/22/12 CAA for dental care showed the resident had no natural teeth or tooth fragments. In addition, s/he had "functional limitation in upper extremity range of motion [ROM]." Because of the resident's limited upper	F 279			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 11 extremity ROM, s/he required assistance with oral hygiene. Review of the care plan last updated 9/10/12 showed oral and dental care was not addressed in the care plan. 3. Review of section V of the 7/24/12 admission MDS assessment for resident #37 showed the following areas triggered for comprehensive review: vision impairment, activities of daily living (ADLs), nutrition, dental care, and pain. According to the CAAs in these areas, upon completion of the comprehensive assessments, staff made a decision to care plan those same areas. Review of the 7/19/12 care plan, however, showed no evidence a care plan was developed to address each of those areas. 4. Review of the 7/18/12 annual MDS assessment for resident #7, section V, revealed vision impairment triggered for comprehensive review. According to the CAA, after performing the comprehensive assessment, staff made a decision to develop a care plan to address visual impairment. However, review of the 7/27/12 care plan showed visual impairment was not addressed in the care plan. 5. Review of the 5/14/12 annual MDS assessment, section V, for resident #40 revealed s/he triggered in several areas including nutritional status, hydration and oral/dental. However, review of the resident's care plan showed there were no care plans addressing these three care areas. 6. An interview with the MDS coordinator on 9/20/12 at 12:PM revealed care plans needed to be developed as indicated on the MDS	F 279			

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F 279	Continued From page 12 assessment; section V.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, care plan review, and staff interview, the facility failed to revise and implement the care plan as needed for 1 of 10 sample residents (#17). The findings were: Review of the care plan dated 7/3/12 for resident (#17) showed the resident was at risk for falls. Review of the care plan approaches to prevent falls included the following: monitor the resident for steadiness and balance, assure lighting was	F 280 F 280	Resident #17's care plan (risk for falls dated 7/3/12) was reviewed and revised by 10/31/12 to reflect his/her appropriate level of function at this time. All care plans will be audited/reviewed quarterly in conjunction with completion of quarterly MDS to ensure the care plan is an accurate reflection of the resident's current functional status. Any concerns with the care planning process and care plan accuracy will be reported to the QA committee on a quarterly basis. <i>Ranger</i> <i>Audit of other residents who are at fall risks will complete to ensure care plans are in place by MDS coordinator</i>	10/31/12	<i>Ranger</i> <i>call WNB</i>

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F 280	Continued From page 13 adequate, monitor the environment for wet spots or items placed below field of vision, and to monitor for side effects from medications. However, periodic observations from 9/17/12 through 9/19/12 showed the resident was either seated in a reclining chair or was in bed. An interview on 9/18/12 at 10:48 AM with CNA#1 revealed "The staff always uses a lift to transfer the resident from chair to bed." During an interview on 9/19/12 at 2:23 PM with RN #1 she stated "It has been about a year since the resident was able to stand to transfer. For the past year we have only used a Hoyer lift to transfer the resident from bed to chair and back." Further interview verified the current care plan was not updated to accurately reflect the resident's current status.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and and staff interview, the facility failed to consistently follow written physician orders for 2 of 10 sample residents (#7, #37). In addition, the facility failed to ensure staff clarified physician orders for 1 of 10 sample residents (#17). The findings were: In regard to not following physician orders: 1. Review of the 8/11/11 hospital history and physical and the medical record showed resident #37 had diagnoses including hypertension.	F 281	F 281 In regard to not following physician orders: 1. On 9/21/12 the Metoprolol order for resident #37 was clarified to 25 mg one tab every day. The medication is now being given as ordered. The nursing staff was educated on 9/28/12 how to accurately record glucometer readings in the EMR. Additionally staff have been instructed that blood sugar values must be recorded in EMR when blood sugar is checked. Nursing staff in-service to be held on 10/15/12 to review with staff the importance of following physician orders and the procedure for blood sugar recording. Staff was educated on 9/28/12 on how to accurately record O2 sats in the EMR. In-service to be held on 10/15/12 to review with nursing staff the importance of following physician orders and to show staff how to document vital signs (including O2 sats) on the EMR.	10/31/12	

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F 281	Continued From page 14 Review of the August 2012 and September 2012 physician recapitulation of orders for the resident showed an order, originally written on 8/3/11, for Metoprolol 25 milligrams (mg) to be administered daily if his/her blood pressure (B/P) reading was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified this order meant the resident should be administered the Metoprolol only if the B/P was greater than 200/100; not on a daily basis. The following concerns were identified: a. Review of the MARS, TARs, and nursing notes for July 2012, August 2012, and September 2012 revealed the Metoprolol was administered every day with no evidence the resident's B/P was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified not only was it administered daily during those months, but that the medication had been given daily since the order was written thirteen months ago on 8/3/11. b. Review of the MARS, TARs, vital signs report, and nursing notes for July 2012, August 2012, and September 2012 revealed the resident's B/P was not checked daily so it was unknown if the medication was necessary or not. Review of these documents showed the resident's B/P was checked only one day in July 2012; five days in August 2012, and once in September to date (9/19/12). c. During an interview with the DON on 9/20/12 at 12:15 PM, he verified staff had not followed the physician's orders as written and had, therefore, potentially administered the medication incorrectly for more than one year. In addition, review of the medical record for resident #37 showed s/he was admitted with diagnoses including Diabetes. Review of the August 2012 and September 2012 physician	F 281	2. On 10/10/12 resident #7's record, including physician orders, were reviewed. It was determined the resident still needs to have his/her O2 saturation check every shift. Staff was educated on 9/28/12 on how to accurately record O2 sats, in the EMR. It was found that the method for entering O2 saturations into the EMR was problematic and this led to omissions of data. The EMR reporting was revised to include accurate, consistent measurement of O2 saturations per physician orders. In-service to be held on 10/15/12 to review with nursing staff the importance of following physician orders.		

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F 281	Continued From page 15 recapitulation of orders showed an order for fingerstick blood sugars twice daily on Tuesdays and Thursdays and as needed. The order was originally written on 8/2/11. Review of the August 2012 MAR showed the resident's blood sugar was not obtained twice daily as ordered on 8/9/12, 8/28/12 and on 8/30/12. Interview with the DON on 9/20/12 at 12:15 PM verified this information was accurate and that staff should have followed the physician's order. Finally, review of the August 2012 and September 2012 physician's orders showed an order for oxygen saturation (O2 sat) readings twice daily and as needed. Review of the MAR and TAR from 8/20/12 through 9/19/12 showed staff did not obtain the O2 sats as ordered on 13 of the 31 days. On 7 of the 13 days the O2 sats were obtained once and on 6 of the 13 days the O2 sats were not obtained at all. Interview with the DON on 9/20/12 at 12:15 PM verified the physician's order was not followed as written but that it should have been. 2. Review of the 7/18/12 re-admission MDS assessment for resident #7 showed s/he had shortness of breath while lying flat and upon exertion. Review of the August 2012 and September 2012 physician's recapitulation of orders for this resident showed a treatment order to check his/her O2 levels every shift on a daily basis. According to the August 2012 and September 2012 MARs, this order was originally written upon the resident's re-admission to the facility on 7/26/12. The following concerns were identified: a. Review of the medical record showed the resident's O2 sats were not taken on 8/7/12 and 9/5/12.	F 281	In regard to not clarifying physician orders: 1. Resident #17's medical record was reviewed on 10/8/12 It was determined the resident had not used the Lasix for a number of months. The order was discontinued on 10/8/12. Any new order that is ambiguous will be clarified by the nurse receiving the order. In-service to be held on 10/15/12 to review with nursing staff the importance of clarifying physician orders. Additionally, the night nurse and/or the Unit Manager will review new orders for accuracy and to ensure there is no ambiguity in the order. If any problem or ambiguity is found, the order will be clarified with the physician.		

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F 281	Continued From page 16 b. Review of the medical record showed the resident's O2 sats were obtained only once instead of every shift as ordered on eleven days during the months of August 2012 and to date in September 2012. c. The DON verified the above information was correct on 9/20/12 at 12:15 PM. He further said physician orders should always be followed. 3. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. In regard to not clarifying physician orders: 1. Review of the September 2012 MAR for resident #17 showed s/he was prescribed Lasix 20 mg to be administered every other day and prn (as needed) for edema. Further review of the MAR revealed the order was initiated 2/20/12. Interview with LPN #1 on 9/18/12 at 3:38 PM revealed she did not know to what degree of edema would need to be apparent before carrying out the order. During the interview with the LPN, she said the order should be clarified and specific edema parameters should be established as to when the Lasix would be given PRN. 2. According to "Nursing Malpractice" by Hanh Helm, copyright 2003, "...don't carry out any order from a physician if you have doubts about its accuracy or appropriateness. Follow your facility's policy for clarifying ambiguous orders." Furthermore, the sixth edition of "Clinical Nursing Skills: Basic to Advanced Skills" by Smith, Duell,	F 281			

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F 281	Continued From page 17 and Martin notes, "If a written order is ...questionable for any reason, the physician must be notified for clarification."	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility lacked evidence nursing staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 1 of 4 sample residents (#34) who had pain. The findings were: 1. Review of the medical record for resident #34 showed s/he was admitted with diagnoses including Rheumatoid arthritis and chronic pain. Review of the 5/3/12 admission MDS assessment for the resident showed s/he had pain frequently which had made it difficult to sleep at night. The resident rated the worst pain as 7 out of 10 on a scale of 0 to 10 with 10 being the worst (7/10). Review of the 5/3/12 care area assessment (CAA) for this resident showed the pain was musculoskeletal (osteoarthritis) and limited his/her day-to-day activities. Continued review of the CAA showed the resident was currently on methadone and percocet, both narcotic pain	F 309	F 309 Resident #34's pain management care plan will be reviewed and revisions made by 10/31/12. Other non-pharmacologic interventions will be included as appropriate in the care plan in addition to turning and repositioning. Nursing staff was in-serviced on 10/15/12 regarding the use of non-pharmacologic interventions for pain relief. The nursing staff was shown where to chart these interventions in the EMR. Resident #34's pain assessment will be completed on or before 10/12/12. All assessments, including the pain assessment, will be completed in conjunction with admission and with quarterly MDSs. Any concerns regarding pain management will be reported to the QA committee.	10/31/12	

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F 309	Continued From page 18 medications, yet s/he continued to express a need for PRN (as needed) pain medication. According to the CAA, the resident spent most of the time in bed and could not sit upright or reposition him/herself. Review of the 7/24/12 quarterly MDS assessment for the resident showed s/he was on a scheduled pain medication regimen for a diagnosis of chronic pain, osteoarthritis, and Rheumatoid arthritis. Review also revealed s/he had received or was offered pain medication in the past five days. Review of the September 2012 physician's orders showed an order for scheduled methadone 60 milligrams (mg) twice daily and Lortab 7.5/500 (mg) one tablet every 4 to 6 hours as needed for breakthrough pain. The following concerns with pain management were identified: a. Review of the computerized medical record revealed the resident complained of pain rated at 6/10 on 9/9/12 at 5:39 PM. The resident was administered a Lortab 7.5/500 mg tablet for the pain. Upon re-assessment at 6:24 PM the resident rated the pain at 5/10; minimal improvement. Review of the medical record revealed no evidence other alternatives were attempted to further reduce the resident's level of pain. Review of the 7/30/12 care plan showed only one non-pharmacological intervention was included which was turning and repositioning. Review of the medical record showed no evidence turning or repositioning was attempted to further alleviate the resident's pain. In addition, review of the care plan showed no evidence an acceptable level of pain was established for the resident. b. Review of the computerized medical record showed under the heading of pain assessment, "no entries" was written. Interview	F 309			

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F 309	Continued From page 19 with the DON on 9/20/12 at 12:15 PM revealed "no entries" indicated no comprehensive pain assessment was performed, even though pain triggered for further review on the 5/3/12 admission MDS assessment. He verified a comprehensive pain assessment should have been performed and an acceptable level of pain determined for this resident.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate incontinence care was provided for 3 of 10 sample residents (#18, #33, #37). The findings were: 1. Observation on 9/18/12 at 9 AM showed CNA #2 and NA #1 assisted resident #18 with incontinence care. Observation showed NA #1 cleansed the resident's coccyx but did not cleanse his/her perineum where urine had contact with the skin. Review of the resident's 6/22/12 annual MDS assessment showed the resident required extensive assistance with toilet use and personal hygiene. An interview with CNA #2 on 9/20/12 at 9:45 AM revealed the resident's anterior perineum should have been cleansed,	F 312	F 312	Peri care in-service to be held for CNA staff on 10/31/12. Special focus to be made on proper cleaning of the peri area. Random audits of peri-care will be conducted once per month by Unit Manager for the next quarter and as needed thereafter. Any concerns will be reported to the QA committee.	10/31/12

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F 312	Continued From page 20 2. Review of the Incompleted 9/7/12 admission MDS assessment for resident #33 revealed he required extensive staff assistance with toileting and personal hygiene. Observation on 9/18/12 at 10:40 AM showed the resident was incontinent of urine and feces. Continued observation showed CNA #1 provided perineal care but failed to pull back the foreskin of the penis that was soiled with feces in order to cleanse that area. Interview with CNA #1 on 9/20/12 at 8:58 AM revealed she knew the proper way to provide perineal care. During an interview with the infection control coordinator on 9/20/12 at 9:30 AM, she said an inservice on proper perineal care had recently been provided and that she was disappointed the procedure was not properly followed. 3. Review of the 7/24/12 annual MDS assessment for resident #37 showed s/he required extensive staff assistance with toileting and personal hygiene. Further review of this document showed the resident was frequently incontinent of urine and feces. Observation on 9/18/12 at 9:15 AM revealed CNA #3 assisted the resident to the bathroom. The CNA removed the resident's incontinence brief which was saturated with urine and provided perineal care. Observation showed the CNA did not cleanse the anterior perineal area or the buttocks, both of which had contact with the urine saturated incontinence brief. Interview with the infection control coordinator on 9/20/12 at 9:30 AM revealed all skin surface areas that had contact with a wet, soiled incontinence brief should be cleansed.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314			

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F 314	Continued From page 21 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of the facility's policies and procedures, the facility failed to appropriately identify, treat, and monitor a pressure ulcer for 1 of 4 sample residents (#18) identified as being at risk for developing pressure ulcers. The findings were: Observation on 9/18/12 at 9 AM showed resident #18 had an open skin area located on his left right buttock. The open area was found while incontinence care was being provided by CNA #2 and NA #1. The following concerns were identified: a. Observation on 9/19/12 at 4:20 PM, with the wound care nurse, revealed the open skin area on the resident's right buttock measured 0.5 centimeters in diameter with no depth. At that time, the nurse stated no one had reported the open area to her and she was not aware of the wound. Further interview with the nurse revealed changes in skin integrity should be reported to a licensed nurse right away. b. Review of the 9/10/12 care plan for skin integrity showed changes in the skin should be	F 314	F 314 The open area on resident #18's skin was addressed by the wound care nurse on 9/19/12. An in-service was held with the nursing staff on 10/31/12 regarding the communication of skin care issues and that skin issues must be communicated to the charge nurse immediately. Staff also educated regarding accurate documentation of daily skin check and communication with charge nurse. This process will be monitored by the wound care nurse and any concerns will be addressed with the QA committee.	10/31/12	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 22 reported to the nurse "Immediately." Review of the 9/18/12 nurses notes showed no evidence the the licensed nursing staff was aware of the skin breakdown. c. Review of the policy and procedure last updated in June 2012 for pressure ulcer prevention, #2014, showed skin inspections were to be completed daily by the nursing assistant and weekly by a licensed staff nurse.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff and resident interviews, the facility failed to ensure the safe use of a sit to stand lift device for 1 of 5 sample residents (#18) who used a lift for transfers. The findings were: Review of the 6/22/12 annual MDS assessment showed resident #18 had diagnoses that included multiple sclerosis and neuropathy (disease of the nerves). Observation on 9/18/12 at 9 AM showed CNA #2 and NA #1 transferred resident #18 from his/her wheelchair to the bed using a sit to stand lift. The following concerns were identified: a. Review of the medical record showed no evidence a safety or transfer assessment was	F 323	F 323 Resident #18 was reviewed for appropriateness of the sit to stand lift. It was found that he/she would be better using a full body lift. He/she is currently compliant with use of the full body hooyer lift. Use of the sit to stand lift has been discontinued for this resident. An assessment tool will be developed by 10/31/12 to ensure the appropriate type of lift is being used for each resident. All residents currently using a lift will be assessed to ensure the appropriate lift is being used. These assessments will be reviewed as needed to ensure the proper lift is being used. Any concerns regarding this process will be reported to the QA committee.	10/31/12	

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F 323	Continued From page 23 performed to determine the appropriate type of lift for this resident. Interview with the DON on 9/20/12 at 11:55 AM verified no safety or transfer assessment was performed. b. An interview with the resident on 9/19/12 at 4:20 PM revealed s/he had pain as a result of the strap that was placed under his/her arms during transfers with the sit to stand lift. c. Observation on 9/18/12 at 9 AM showed the resident was placed in the sit to stand lift to allow CNA #2 and NA #1 to provide incontinence care. Continued observation showed the resident was unable to support him/herself and was hanging from the sling. Based on the standard of care for utilization of lifts, the sit to stand lift should be used for a resident who was able to partially support him/herself. Interview with the DON on 9/20/12 at 11:55 AM revealed the facility did not have a policy and procedure for utilization of a lift in regard to what type would be safest and most appropriate for a resident.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328	F 328 Staff was educated on 9/28/12 on how to accurately record O2 sats in the EMR. In-service to be held on 10/15/12 to review with nursing staff the importance of following physician orders and to show staff how to document vital signs (including O2 sats) on the EMR. This will be monitored for completion on the DON report. Any concerns will be reported to the QA committee.	10/31/12	

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F 328	Continued From page 24 by: Based on medical record review and staff interview, the facility failed to provide adequate oxygen monitoring for 1 of 5 sample residents (#37) who required oxygen. The findings were: Review of the medical record for resident #37 showed s/he had diagnoses including acute respiratory failure and status post aspiration pneumonia. Review of the 3/6/12 pain assessment showed the resident frequently had chest pain related to his/her acute respiratory failure diagnosis. Further review of this document showed the resident had periods when s/he was unable to breathe. Review of the physician's orders showed an order dated 8/2/11 to monitor the resident's respiratory status by obtaining a pulse oximetry (oxygen saturation levels or O2 sats) twice daily. The following concerns were identified: a. Review of the MAR and TAR from 8/20/12 through 9/19/12 showed staff did not obtain the O2 sats as ordered on 13 of the 31 days. On 7 of the 13 days the O2 sats were obtained only once. On 6 of the 13 days the O2 sats were not obtained. b. Interview with the DON on 9/20/12 at 12:15 PM revealed the resident had dementia and sometimes took the oxygen off at which point his/her O2 sats dropped into the 80s immediately. Review of the physician's order showed the resident's O2 sats should be maintained at greater than 90%. During the interview with the DON, he said it was important for the resident to keep the oxygen on at all times and to monitor his/her pulse oximetry readings as ordered based on his/her acute respiratory failure status.	F 328			
F 329	483.25(I) DRUG REGIMEN IS FREE FROM	F 329			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 329 SS=D	Continued From page 25 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure unnecessary medications were not administered for 1 of 10 sample residents (#37). The findings were: Review of the 8/11/11 hospital history and physical and the computerized medical record showed resident #37 had diagnoses including	F 329	F 329 On 9/21/12 resident #37's physician was called and the Metoprolol order was clarified to 25 mg one tab every day. The medication is now being given per the physician order. Based on recent vital signs for resident #37, his/her blood pressure is adequately controlled with current regimen. In-service to be held on 10/15/12 to review with nursing staff the importance of following physician orders. Any orders that are ambiguous will be clarified by the nurse receiving/discovering the order. In-service to be held on 10/15/12 to review with nursing staff the importance of clarifying physician orders. Additionally, the night nurse and/or the Unit Manager will review new orders for accuracy and to ensure there is no ambiguity in the order. If any problem or ambiguity is found, the order will be clarified with the physician. Any concerns will be reported to the QA committee.	10/16/12	

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F 329	Continued From page 28 hypertension. Review of the August 2012 and September 2012 physician recapitulation of orders for the resident showed an order, originally written on 8/3/11, for Metoprolol 25 milligrams (mg) to be administered daily if his/her blood pressure (B/P) reading was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified this order meant the resident should be administered the Metoprolol only if the B/P was greater than 200/100; not on a daily basis. The following concerns were identified: a. Review of the MARs, TARs, and nursing notes for July 2012, August 2012, and September 2012 revealed the Metoprolol was administered every day with no evidence the resident's B/P was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified not only was it administered daily during those months but had been given daily since the order was written on 8/3/11 (13 months). b. Review of the MARs, TARs, vital signs report, and nursing notes for July 2012, August 2012, and September 2012 revealed the resident's B/P was not checked daily so staff would know whether to administer the Metoprolol or not. Review of these documents showed the resident's B/P was checked only one day in July 2012, five days in August 2012, and once in September to date (9/19/12). c. Interview with the DON on 9/20/12 at 12:15 PM verified the medication probably had been administered unnecessarily for greater than one year.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 333	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician orders in regard to antihypertensive medication administration for 1 of 10 sample residents (#37). The antihypertensive medication was administered daily without monitoring and without following the blood pressure parameters included in the physician's order for greater than one year. This lack of following physician orders resulted in a significant medication error. The findings were: Review of the 8/11/11 hospital history and physical and the computerized medical record showed resident #37 had diagnoses including hypertension. Review of the August 2012 and September 2012 physician recapitulation of orders for the resident showed an order, originally written on 8/3/11, for Metoprolol 25 milligrams (mg) to be administered daily if his/her blood pressure (B/P) reading was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified this order meant the resident should be administered the Metoprolol only if the B/P was greater than 200/100; not on a daily basis. The following concerns were identified: a. Review of the MARs, TARs, and nursing notes for July 2012, August 2012, and September 2012 revealed the Metoprolol was administered every day with no evidence the resident's B/P was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified not only was it administered daily during those months but had been given daily since the order was written on	F 333	F 333 On 9/21/12 resident #37's physician was called and the Metoprolol order was clarified to 25 mg one tab every day. The medication is now being given per the physician order. Based on recent vital signs for resident #37, his/her blood pressure is adequately controlled with current regimen. In-service to be held on 10/15/12 to review with nursing staff the importance of following physician orders. Any new order that is ambiguous will be clarified by the nurse receiving the order. In-service to be held on 10/15/12 to review with nursing staff the importance of clarifying physician orders. Additionally, the night nurse and/or the Unit Manager will review new orders for accuracy and to ensure there is no ambiguity in the order. If any problem or ambiguity is found, the order will be clarified with the physician. Any concerns will be reported to the QA committee.	10/16/12	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 333	Continued From page 28 8/3/11, 13 months ago. b. Review of the MARs, TARs, vital signs report, and nursing notes for July 2012, August 2012, and September 2012 revealed the resident's B/P was not checked daily so staff would know whether to administer the Metoprolol or not. Review of these documents showed the resident's B/P was checked only one day in July 2012, five days in August 2012, and once in September to date (9/19/12). Review revealed at no time was the resident's B/P greater than 200/100. c. Interview with the DON on 9/20/12 at 12:15 PM verified the medication had most probably been administered incorrectly for greater than one year.	F 333			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food in 1 of 2 freezers and other areas of the kitchen were not exposed to possible contaminants. The findings were: 1. Observations on 09/17/12 at 4:48 PM, on	F 371	1. The cleaning schedule for the air return grate in the kitchen freezer has been revised. The grate will be checked every week when the grocery order is received. If cleaning is needed, it will be cleaned at that time. The formal cleaning schedule for the grate has been revised to twice per month instead of once per month. Any concerns about cleanliness of the freezer grate will be reported in the quarterly QA meeting. 2. In-service with dietary staff will be conducted on 10/31/12 regarding the proper handling of food. Staff reminded not to place food on trash receptacle lid. Dietary manger will monitor for compliance and will report any concerns to the QA committee.	10/31/12	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 371	Continued From page 29 09/18/12 at 9:00 AM and on 09/19/12 at 3:30 PM revealed the air return grate in the kitchen freezer had a visible accumulation of dirt and dust. Interview with the dietary manager on 09/19/12 at 2:48 PM revealed she was not aware the vent was dirty. She stated the air vents in both the freezer and the refrigerator were cleaned at the same time and she did not know why the freezer grate would get dirtier than the one in the refrigerator. According to the 2009 Food Code, U.S. Public Health Service, 4-601.11, Equipment, Nonfood-Contact Surfaces. (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris 2. Observation on 09/19/12 at 11:45 AM revealed an unopened gallon jug of fruit juice sitting on the kitchen garbage can. Interview with the dietary manager at that time revealed she was aware that resident food items should not be placed on the garbage can.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 On 9/21/12 resident #37's physician was called and the Metoprolol order was clarified to 25 mg one tab every day. The medication is now being given per the physician order. Consultant pharmacist was contacted by the DON to discuss concerns with drug review. Pharmacist will look more closely at parameters for medication administration and advise when corrections are needed. Any concerns found during drug review will be reported to QA committee.	10/16/12	

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F 428	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the pharmacist identified the potential administration of an unnecessary medication during the drug regimen review for 1 of 10 sample residents (#37). The findings were: Review of the 8/11/11 hospital history and physical and the computerized medical record showed resident #37 had diagnoses including hypertension. Review of the August 2012 and September 2012 physician recapitulation of orders for the resident showed an order, originally written on 8/3/11, for Metoprolol 25 milligrams (mg) to be administered daily if his/her blood pressure (B/P) reading was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified this order meant the resident should be administered the Metoprolol only if the B/P was greater than 200/100; not on a daily basis. The following concerns were identified: a. Review of the MARs, TARs, and nursing notes for July 2012, August 2012, and September 2012 revealed the Metoprolol was administered every day with no evidence the resident's B/P was greater than 200/100. Interview with the DON on 9/20/12 at 12:15 PM verified not only was it administered daily during those months but had been given daily since the order was written on 8/3/11 (13 months). b. Review of the MARs, TARs, vital signs report, and nursing notes for July 2012, August 2012, and September 2012 revealed the resident's B/P was not checked daily so staff would know whether to administer the Metoprolol	F 428			

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F 428	Continued From page 31 or not. Review of these documents showed the resident's B/P was checked only one day in July 2012, five days in August 2012, and once in September to date (9/19/12). None of the B/P readings were greater than 200/100. c. Review of the pharmacy drug regimen reviews for July 2012, August 2012, and September 2012 showed no evidence the order to administer Metoprolol only if the B/P was over 200/100 was questioned and the pharmacy had delivered thirty days worth of Metoprolol every month since the order was written. The drug regimen review also did not address the fact the resident's B/P was not checked on a daily basis and when it was checked it was not greater than 200/100. d. Interview with the DON on 9/20/12 at 12:15 PM verified the drug regimen review reports did not question the order and the pharmacy continued to deliver thirty day's supply of Metoprolol every month since the order was written over one year ago.	F 428			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F 441 1. Hand washing in-service will be conducted on 10/31/12 for staff. Protocol for putting on and taking off gloves will be discussed at that time. Hand washing audits will be completed by the infection control nurse on 10 staff members in the month of October and as needed thereafter. The results of the hand washing audit will be shared with the QA committee and appropriate action, if needed, will be taken. 2. Hand washing in-service will be conducted on 10/31/12 for staff. Protocol for disposing of paper towels after cleaning hands will be discussed at that time. Hand washing audits will be completed by the infection control nurse on 10 staff members, including kitchen staff, in the month of October and as needed thereafter. The results of the hand washing audit will be shared with the QA committee and appropriate action, if needed, will be taken.	10/31/12	

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10/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page 32 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and facility policies and procedures, the facility failed to ensure staff followed the accepted standards of practice in regard to hand washing and infection control practices during 2 of 4 random observations affecting residents #19 and #33. In addition, the facility failed to ensure staff followed the accepted standards of practice in regard to hand hygiene during 1 of 4 kitchen observations. The findings were:	F 441			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 441	Continued From page 33 1. Review of the incomplete 9/7/12 admission MDS assessment for resident #33 revealed s/he required extensive staff assistance with toileting and personal hygiene. Observation on 9/18/12 at 10:40 AM showed the resident was incontinent of urine and feces. Continued observation showed CNA #1 assisted the resident to sit on the toilet, then she removed his/her soiled sweat pants, sweatshirt, and incontinence brief. Observation showed both the sweat pants and the sweatshirt were saturated with urine and some feces. After removing the resident's soiled clothing the CNA went to the closet to obtain clean clothing. After moving several items on hangers back and forth, the CNA selected a clean outfit and returned to the bathroom with the clean clothing. The CNA placed the clean sweat pants and clean incontinence brief partially on the resident (up to his/her knees) and then placed the clean sweatshirt on the resident. All of these tasks were completed using the same soiled gloves the CNA had used to remove the soiled brief and clothing. Interview with the infection control coordinator on 9/20/12 at 9:30 AM revealed the CNA should have removed her gloves after removing the soiled clothing, washed her hands, and then put on a new pair of gloves prior to obtaining clean clothing. 2. Observation on 9/18/12 at 9 AM showed NA #1 completed incontinence care for resident #19 with gloved hands. The NA removed her gloves and continued to assist the resident without first performing hand hygiene. The NA adjusted the resident's blankets and assisted him/her with a drink of water. An interview on 9/20/10 at 9:45 AM with CNA #2 revealed hands are to be cleansed after removing gloves and before continuing other	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 resident care. 3. Observation on 9/17/12 at 5:48 PM showed three kitchen staff preparing resident food trays for the evening meal. One staff member (name unknown) was called away from the tray line in order to do some other type of work in the kitchen. Upon return to the tray line, the staff member went to the kitchen hand washing sink and washed her hands. She took a paper towel from the dispenser and dried her hands; then went to the kitchen garbage can, lifted the lid with her clean hand and dropped the wet paper towel into the garbage can. The staff member then went back to assisting the other two staff with tray preparations. 4. Review of the facility's policy and procedure, #0026, for hand washing last dated 5/22/98 showed: "Appropriate ten (10) to fifteen (15) second hand washing must be performed under the following conditions: ...After contact with blood, body fluids, excretions, secretions, mucous membranes or non-intact skin;... After removing gloves."	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by:	F 492	F 492 1. The personnel file for CNA #4 was reviewed. The questionnaire was completed in full for CNA #4 and all questions addressed, as well as being signed and dated. This staff member has no active signs/symptoms of TB. 2. The personnel file for LPN #2 was reviewed. The medical assessment (questionnaire) was completed in full and all questions addressed, as well as being signed and dated. This staff member has no active sign/symptoms of TB. The medical assessment (questionnaire) given to new hires was revised to reflect the need for symptoms of TB to be addressed (#9 on the questionnaire). The line 'none of the above' was added to ensure this question is being addressed on all questionnaires. The HR/payroll staff will ensure each questionnaire is completed in its entirety and that each question is addressed on every new hire. Any concerns will be addressed immediately and reported to the QA committee.	10/8/12

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE - EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE
475 YELLOW CREEK ROAD
EVANSTON, WY 82930

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F 492	Continued From page 35 Based on staff interview and review of employee records, the facility failed to ensure state rules and regulations were followed related to TB screening for 2 of 8 staff members prior to resident contact. The findings were: 1. Review of personnel files showed CNA #4 was hired on 8/27/12. Further review revealed she was not given a TB (tuberculin) skin test at that time because her medical history showed a previous TB skin test was positive on 5/15/06. She was treated with INH (medication to treat TB) at that time. She did not complete the course of treatment, however, due to a severe reaction to the drug. Additional review of the medical record revealed a medical assessment (questionnaire) was present in the medical record but it was incomplete, i.e. the presence or absence of signs or symptoms of TB were not indicated and the questionnaire was not dated or signed. 2. Review of personnel files showed LPN #2 was hired on 9/6/12. Further review revealed she was not given a TB skin test at that time because her medical history showed a previous skin test was positive in 1994. She was also treated with INH at that time. Further review revealed she also had a negative chest x-ray in 2008. Additional review of the medical record revealed a medical assessment (questionnaire) was found in the record but it was incomplete, i.e. the presence or absence of signs or symptoms of TB were not indicated and the questionnaire was not dated or signed. 3. Interview with the infection control nurse on 9/19/12 at 3:48 PM verified the medical assessment (questionnaire) was incomplete for	F 492		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 492	Continued From page 36 both staff members. She further said a more thorough assessment should have been performed.	F 492			